Payment Policy: Leveling of Care: Emergency Department Evaluation and Management Overcoding for Facility Services

Reference Number: CC.PP.80
Product Type: All
Date of Last Revision: 04/2026

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
According to the Federal Registrar and the American College of Emergency Physicians, emergency department (ED) facility evaluation and management (E/M) levels are based primarily on the hospital resources utilized by the facility and staff of the ED to evaluate and manage the patient. Facility resources may include nursing time, clinical staff effort, supplies, equipment, overhead and other resources directly related to the patient's care. Unlike professional E/M codes, which reflect the clinical complexity and intensity of the provider's, facility E/M codes are intended to represent the amount and intensity of facility resources used during the emergency department encounter.

Application
Outpatient facility emergency departments

Policy Description
This policy supports reviews of facility-reported ED E/M levels for consistency with resources reported on the claim, including laboratory services, imaging, procedures, treatments, and other billed services. When the billed level of service is not supported by the claim evidence, reimbursement will be adjusted to the appropriate ED E/M level, up to and including the minimum level of service, based on the resources documented on the claim.

Appeal and Medical Records Review
Facilities may appeal the reimbursement adjustment by submitting medical records or other relevant documentation that supports the billed ED E/M level. Documentation should clearly demonstrate the facility resources used during the encounter, including services, interventions, monitoring, supplies, staff effort, and other resources necessary to support the reported level of service.

Reimbursement Guidelines
The health plan utilizes an automated, pre-payment (after services are rendered, but prior to claims payment) claims review process to evaluate facility ED E/M claims for coding accuracy and consistency with services reported on the claim.

When the billed E/M level is not supported by the claim information submitted, reimbursement will be adjusted to the appropriate level of service based on the claim evidence.

Review of selected claims may include consideration of billed services associated with the ED, including, but not limited to procedures, diagnostics, treatments, and other reported claim information.

ED E/M services will not be denied per this policy; however, the billed level of service may be reduced when claim information supports a lower level.

The lowest E/M level of service to which an ED facility service may be adjusted per this policy is Level 3 (CPT 99283/HCPCS G0382).

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Revenue Codes	Descriptor
N/A	N/A

CPT/HCPCS Codes	Descriptor
99281	Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional
99282	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
99283	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making

CPT/HCPCS Codes	Descriptor
99284	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
99285	Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making
G0380	Level 1 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0381	Level 2 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment) 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-

CPT/HCPCS Codes	Descriptor
	third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0382	Level 3 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0383	Level 4 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)
G0384	Level 5 hospital emergency department visit provided in a type B emergency department; (the ED must meet at least one of the following requirements: (1) it is licensed by the state in which it is located under applicable state law as an emergency room or emergency department; (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) during the calendar year immediately preceding the calendar year in which a determination under 42 CFR 489.24 is being made, based on a representative sample of patient visits that occurred during that

CPT/HCPCS Codes	Descriptor
	calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment)

Definitions:

Evaluation and Management Services: A medical coding process to support medical billing. Health care providers use E/M codes to be reimbursed by Medicare, Medicaid and commercial insurers. These codes represent the facility's operational and resource-related costs associated with a patient encounter. E/M codes are based on the CPT codes established by the AMA.

Overcoding: Billing procedure codes at a higher level than what is warranted by the medical record documentation.

References

1. *Current Procedural Terminology (CPT®)*, 2025
2. *Centers for Medicare and Medicaid Services,* CMS Manual System and other CMS publications and services.
3. *Federal Register*: 65 FR 18434, "Medicare Program; Prospective Payment System for Hospital Outpatient Services; Final Rule," April 7, 2000, p. 18451.
4. *American College of Emergency Physicians (ACEP)***.** "ED Facility Level Coding Guidelines." Accessed April 7, 2026. https://www.acep.org/administration/reimbursement/ed-facility-level-coding-guidelines.

Revision History	
4/07/2026	Policy developed.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

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